

HIV FUTURES II

HIV positive heterosexual men

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HIV Futures I and II community reports can be found on the HIV Futures website:
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Detailed analyses of sexual behaviour and condom use are reported in the document 'HIV Futures II: The Health and Well-Being of People with HIV/AIDS in Australia' (Grierson et al 2000).

INTRODUCTION

This report is the second to document the experiences of heterosexual men living with HIV/AIDS in Australia. It brings up to date the findings published in *A Different Epidemic: HIV Positive Heterosexual Men in the HIV Futures Survey* (de Visser et al 1999) with data from the second HIV Futures Study (Grierson et al 2000).

The HIV Futures Project aims to explore the relationship between the health and treatment experiences of Australian people living with HIV/AIDS (PLWHA) and their social context. As a central part of this project, the HIV Futures Survey brings together data from a broad range of PLWHA across all population groups in all states and territories in Australia. We present the data on heterosexual men within a separate report in response to the constituency needs of community sector organisations that provide services to HIV positive heterosexual men. The study also recognises the significance of sexuality and gender in the experience of HIV and that heterosexual male PLWHA can at times be an invisible group.

When heterosexual men appear in the HIV/AIDS literature, it is generally within the context of risk and prevention (for example, Marks and Crepaz 2001, Rotheram-Borus et al 2000). When HIV positive heterosexual men are discussed, it is most often within developing country settings (for example, Chandra et al 1998), or within the context of other issues such as reproduction (for example, Chen et al 2001), race (for example, Peterson et al 1996), haemophilia (for example Tanaka et al 1999) or injection drug use (for example, Diaz et al 2001). On occasion, positive heterosexual men appear as the objects of community perception and stigma (for example Leiker et al 1995), but rarely as those experiencing HIV, with intrinsically important concerns regarding quality of life. This report attempts is some small way to redress that imbalance, with an analysis of the data from HIV positive heterosexual men on their lived experience of HIV.

The findings presented in this report should be read in conjunction with the main community report (Grierson et al 2000) and the report on PLWHA with haemophilia (McDonald and Grierson 2000).

In large part the experience of heterosexual male PLWHAs has shifted from the findings of the 1997 survey where there were many differences between this population and other PLWHA. In the 1999 data, there is more similarity than difference. This is particularly clear in the area of treatments, where antiretroviral uptake, and attitudes toward treatment now show no difference between heterosexual men and other PLWHA.

We hope that this report will be useful for services that cater specifically to the needs of heterosexual male PLWHA, and a reminder to others of the experiences and needs of this population in the context of the Australian epidemic.

The survey instrument

The HIV Futures II survey was an anonymous, self-complete, mail-back questionnaire consisting of 193 items organised into eight sections: demographics; accommodation; health and treatments; services and organisations; sex and relationships; employment; recreational drug use; and finances. Each section included an explanation of the purpose of the items. Most items in the survey were closed-coded with either single or multiple response options. A category of 'other' was included for most items to ensure that significant experiences of living with HIV were not excluded. There were a number of attitude/belief items scored using four and five point Likert scales. There were also write-in and open ended items.

The survey, once completed, was returned in a reply-paid envelope to the Living with HIV program. In addition participants were given the option, via a separate mail-back, of adding their contact details to the program mailing list to receive reports and to participate in further research.

The instrument was based in large part on the original HIV Futures survey (Ezzy et al 1998) with most items retained in their original format to allow comparisons between the two studies. Additional sections and items were included to reflect the changes in both the personal experiences of living with HIV/AIDS, and the changes in policy and service context in the past two years.

A series of community consultations with organisations and individuals around the country was conducted prior to the development of the instrument. Particular attention was paid to the strengths and weaknesses of the original survey, and to the changes that had been observed in the intervening period. A community reference group with members drawn from state and national AIDS and PLWHA organisations was established early in the development of the instrument. This group ensured that the instrument was appropriate in language, style and focus. The group also provided feedback on the meaning and implication of the findings prior to the preparation of this report.

A copy of the survey instrument is available for perusal on the website www.latrobe.edu.au/hiv-futures

Recruitment

As the broad aim of this study was to represent the collective and individual experiences of people with HIV/AIDS in Australia, a purposive, multi-faceted community sampling strategy was employed. Participants were recruited using a multi-pronged approach including mail-out, organisational distribution, and advertisement. Participants from the original HIV Futures study mailing list were sent two copies of the survey and were asked to pass the second copy onto anyone they knew who may not have received a copy. Advertisements inviting PLWHA

to participate in the study were placed in HIV/AIDS and community based publications. Press releases were issued to both mainstream and community press promoting the launch of the study. A website was established where PLWHA could either request a copy of the survey or download one. Central to the recruitment strategy was the involvement of community organisations who distributed copies of the surveys to their members and promoted the surveys in their publications. Copies of the survey were mailed out in issues of *Talkabout*, *Positive Life* and *QPP Alive*.

Active recruitment took place between August and October 1999, although a small number of surveys were returned during November and early December and these were included in the analysis.

The people who completed the survey

The survey was completed by a total of 924 respondents. This sample represents 8% of all PLWHA in Australia. Respondents' ages ranged from 18 to 77 years (median = 38.0 years, mean = 41 years). The average time since respondents first tested HIV seropositive was 9.8 years. The results relating to the total sample are reported in the document *HIV Futures II: Health, The Health and Well-Being of People with HIV/AIDS in Australia* (Grierson, Bartos, de Visser and McDonald, 2000).

MAJOR FINDINGS

The HIV Futures Survey was completed by 141 respondents (15%) who described themselves as heterosexual. Of these, 49% were men and 51% women. This gives a total sample of 69 heterosexual men. The age of the heterosexual male respondents ranged from 25 to 74 years. The average age for heterosexual male PLWHA was 41.7 years, which is similar to that of heterosexual women (37.5 years), but significantly less than that of homosexual/bisexual men (42.7 years). On average, heterosexual male PLWHA had been HIV seropositive for 9.3 years - a similar length of time to that reported by homosexual/bisexual men (9.0 years), but significantly longer than that reported by heterosexual women (6.5 years).

Of the 69 heterosexual men in the survey, the majority live in Victoria (41%), NSW (33%) and Queensland (10%), with smaller proportions living in other states and territories.

Table 1 shows the modes of infection with HIV reported by various groups of PLWHA, with over half the men reporting infection through heterosexual contact.

Table 1 Mode of infection for heterosexual men

	Percentage
Heterosexual contact	51
Male homosexual/bisexual contact	14
Injecting drug use (IDU)	14
Blood products/health care setting	5
Male homosexual/bisexual contact + IDU	3
Haemophilia	13

Among heterosexual male respondents, 31% have not completed secondary school, 19% have completed secondary school, 27% have completed a diploma or TAFE qualification and 13% have completed a university degree.

All data in the remainder of this report have been weighted based on mode of infection, gender, state of residence and diagnoses of AIDS defining illness in order to conform to the demographic profile detailed in the Australian HIV Surveillance report.

The results reported below are for the 69 heterosexual male PLWHA who completed HIV Futures II.

Current health

Most heterosexual male respondents reported that they currently feel healthy: 19% said that their health is 'excellent', 52% said that their health is 'good', 28% said that their health is 'fair',

and 2% said that their health is 'poor'. Thirty-four percent of the heterosexual male respondents have been diagnosed with an AIDS-defining illness.

More than half (55%) of the heterosexual male respondents have a major health condition other than HIV/AIDS. The most frequently cited 'other' health conditions for heterosexual male PLWHA included hepatitis C, haemophilia, hepatitis B and cardiovascular disease. One in four (24%) of heterosexual male PLWHA have had hepatitis A, 32% have had hepatitis B. In addition, 38% of heterosexual male PLWHA have been diagnosed with hepatitis C. Twenty-one percent of heterosexual male respondents are on medication for anxiety, 27% for depression, and 6% are on anti-psychotic medication.

All of the heterosexual male respondents have taken both a CD4/T-cell test and a viral load test. The results of respondents' most recent CD4/T-cell tests and viral load tests are displayed in Table 2. Seven percent of heterosexual male PLWHA have a CD4/T-cell count below 250 and a viral load above 50,000.

Table 2 Results of serological testing

Description	Result	Percentage
CD4/T-cell count		
	cells/ml blood	
little or no immune damage	over 500	32
moderate immune damage	250 - 500	36
severe immune damage	below 250	32
Viral load		
	copies/ml blood	
below detectable level	below 200 / 500	64
low	500 - 10,000	20
moderate	10,000 - 50,000	7
high	over 50,000	9

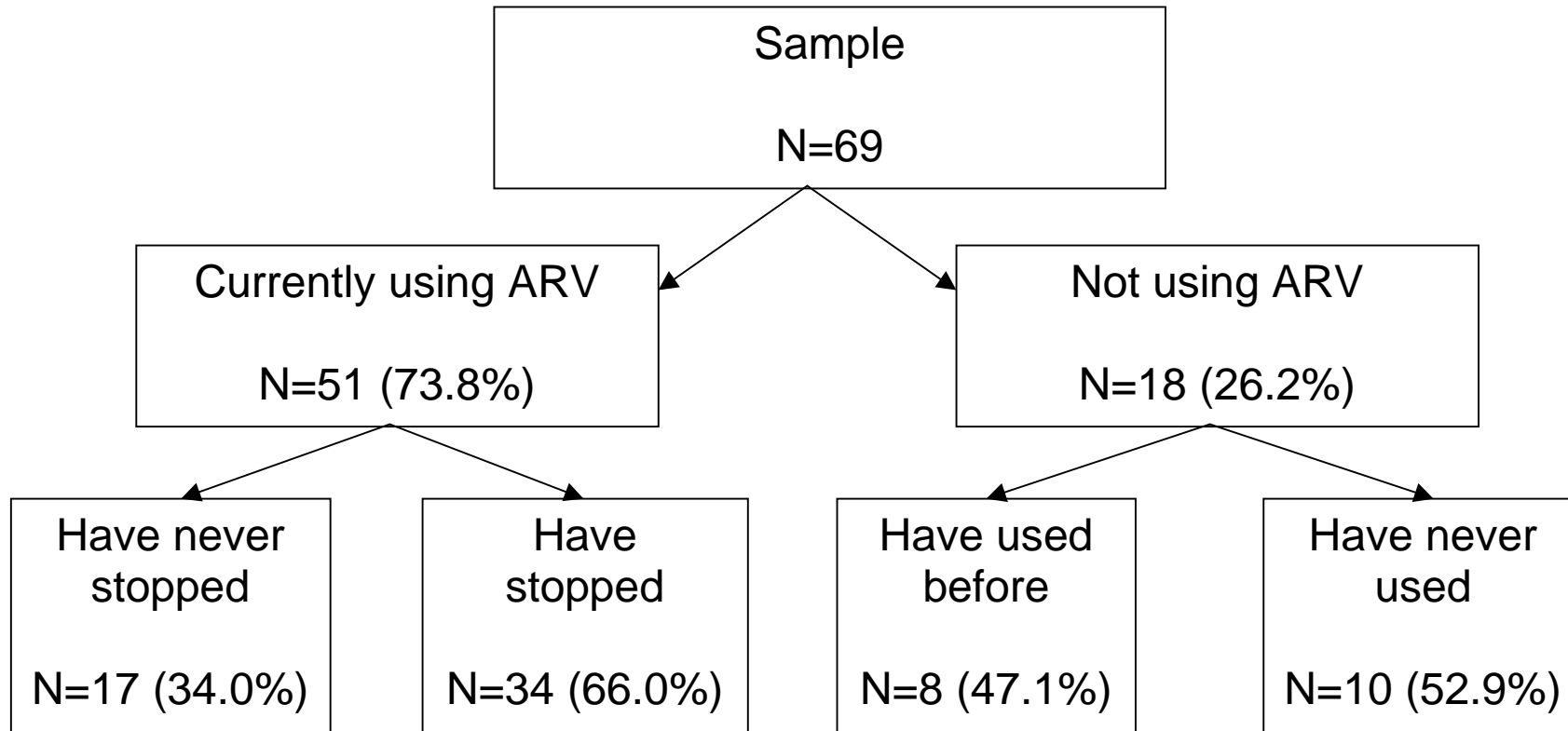
When asked about their CD4/T-cell test results over the last 12 months, 7% of heterosexual men said that they had stayed the same, 31% that they had increased, 56% that they fluctuated, and 7% that they decreased. Heterosexual male respondents were significantly more likely than other PLWHA (38%) to say that their CD4 results had fluctuated. Forty-four percent of heterosexual male respondents reported that their viral load had stayed the same over the last 12 months, 9% that they had increased, 24% that they had fluctuated, and 24% that they had increased.

Antiretroviral treatments

Figure 1 (page 8) shows the uptake of antiretroviral treatment for heterosexual male PLWHA. Almost nine out of ten (86%) of heterosexual male PLWHA have taken antiretroviral drugs at some stage, of these most (87%) are using them currently. In 1997 homosexual/ bisexual

males were more commonly using antiretroviral treatments than both heterosexual males and females. However, in 1999 the proportion of heterosexual men (74%) currently taking antiretrovirals is similar to that of all other PLWHA (74%). Of those heterosexual male PLWHA who are currently taking antiretrovirals 41% report that their health has improved, 24% reported that their health has stayed the same, 35% that it fluctuated. None of these respondents reported that their health has deteriorated while taken antiretrovirals.

Figure 1 The uptake of antiretroviral drugs



Eighty-one percent of heterosexual male PLWHA who use antiretrovirals report difficulties in taking this medication. The most common difficulties among these respondents are remembering to take drugs on time (50%), side effects (48%), organising meals around medication (25%), carrying their medication (23%) and taking a large number of tablets (15%). These proportions are all similar to those for other PLWHA.

Only 10% of heterosexual male PLWHA missed one or more doses on the day before they filled out the survey, with a similar proportion (13%) missing a dose the day before that. Ten percent of heterosexual males missed a dose on both days. Over a third (34%) of heterosexual male PLWHA have taken a break from antiretrovirals at some stage, a similar proportion to that for other PLWHA.

Figure 2 (below) shows that most (68%) of heterosexual male PLWHA agree with the statement that antiretroviral drugs have improved the prospects of most PLWHA, while 16% believe it is too soon to tell, and 14% do not know. Only one heterosexual male PLWHA (2%) believed that antiretroviral drugs have not improved the prospects of PLWHA.

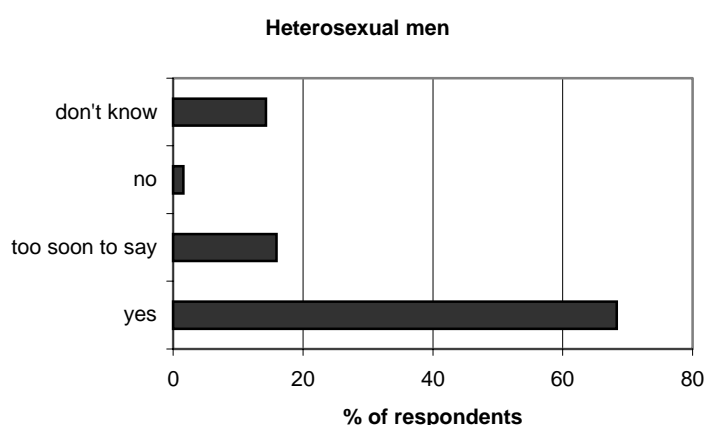


Figure 2 Opinions of heterosexual male respondents on whether antiretrovirals have improved the prospects of PLWHA.

Those heterosexual male PLWHA who are currently using combination therapy have been doing so for an average of 2 years and 8 months. The mean number of combinations they have tried in this time is 2.2, with a mean of 1.4 of these having been used in the past 12 months. They started on these therapies when their viral load was high (mean = 152025.5 copies/ml) and their CD4 count was low (mean = 197.5). The most common circumstances surrounding the commencement of combination therapy for these respondents were doctors' advice (83%), a drop in CD4 count (50%), seeing information that showed this treatment was effective (41%), a big rise in viral load (33%) and becoming ill (28%). Sixty percent of PLWHA currently using combination therapy have changed their combination at least once. Most heterosexual male

PLWHA felt they still had options left – 38% reporting they have many options, 47% a few, 11% one and 4% none.

Those heterosexual male PLWHA who have stopped using antiretrovirals had used them for an average of 3 years 8 months and had stopped on average 3 years 2 months ago. They have used on average 3.1 combinations. Of all heterosexual male PLWHA not currently taking antiretroviral medications, 75% reported that they would consider taking them in the future.

Other treatments for HIV/AIDS

Figure 3 (below) shows that the majority of heterosexual male PLWHA use antiretroviral drugs and most use alternative therapies. 42% of the heterosexual male respondents use prophylaxis for opportunistic infections - prophylaxis for *Pneumocystis carinii* pneumonia (PCP) and/or prophylaxis for other opportunistic infections (OI).

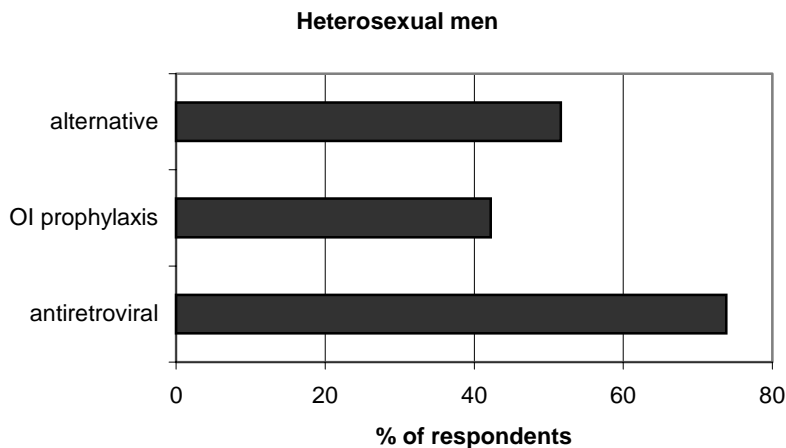


Figure 3 Use of therapies for HIV/AIDS

Heterosexual male respondents are no longer significantly less likely than other groups to be using alternative therapies. Over half (52%) of the heterosexual male respondents use complementary or alternative therapies for HIV/AIDS. The most commonly used complementary/alternative therapies are vitamin/mineral supplements (70% of Heterosexual male PLWHA who use alternative therapies), massage (58%), herbal remedies (33%) and acupuncture (35%).

In contrast to the 1997 findings, the 1999 data indicates that there are no differences between heterosexual men and other PLWHA in ratings of agreement with statements concerning attitudes to antiretroviral medications, alternative therapies and the respondent's attitudes to being personally involved in their own health management.

Table 3 shows the activities respondents engaged in to improve their health.

Table 3 Use of activities to improve health

Activity	Percentage
Exercise	54
Diet	56
Taking pills on time	57
Sleep	46
Relaxation	46
Time spent with pets	17
Complementary therapies	30

Information and support services

In 1997, significantly fewer heterosexual men reported having contact with an HIV/AIDS service organisation than other PLWHA. In 1999, there is no longer a significant difference between heterosexual men (76%) and other PLWHA (79%) having direct contact with an HIV/AIDS-related organisation. Table 4 (below) displays the proportion of heterosexual male PLWHA who use each of the services provided by HIV/AIDS-related organisations. The data show that PLWHA use HIV/AIDS-related organisations for a wide range of services.

Table 4 Use of services provided by HIV/AIDS-related organisations (%)

Service	HIV/AIDS organisation	Other service organisation
Treatments advice	39	15
Social contact with other PLWHA	35	10
Counselling	28	13
Peer support group	23	13
Alternative therapies	22	18
Financial assistance	21	17
Legal advice	18	10
Informal peer support	16	15
Pharmacy services	15	31
Housing assistance	10	12
Library	7	16
Financial advice	7	18
Respite care	5	8
Drug/alcohol treatment	5	13
Return to work skills	3	16
Internet access	3	18
Mental health services	3	10
Employment services	0	12

Respondents were asked to indicate which people and/or organisations they rely upon for information about treatments for HIV/AIDS. Their responses are shown in the Table 5. The most commonly cited source of information about treatments for HIV/AIDS was a doctor specialising in HIV. Doctors specialising in HIV were also most commonly cited (67%) as the most important source of information.

Table 5 Important sources of information on treatments for PLWHA

Activity	Heterosexual males (%)
Doctor specialising in HIV	94
Other doctor	17
Nurse	24
Pharmacist	12
Alternative therapist	18
Treatments officer	29
Other HIV/AIDS organisation staff	31
Positive Women's Organisation	2
Injecting drug user's organisation	6
Haemophilia Foundation	10
HIV positive friends	25
Other friends	12
Partner/lover	16
Family	9
Gay press	9
HIV magazine/newspaper	41
Internet	14

Table 6 (next page) displays the responses of PLWHA to questions they were asked who they rely on for information about living with HIV/AIDS (but not about treatments). The sources of information about living with HIV/AIDS most frequently cited as being important were an HIV magazine or newspaper, a doctor specialising in HIV and AIDS organisation staff. HIV magazines and newspapers (25%) were most commonly cited as the *most* important source of information on living with HIV/AIDS.

Table 6 Important sources of information on living with HIV/AIDS for PLWHA

Activity	Heterosexual males (%)
Doctor specialising in HIV	41
Other doctor	11
Nurse	22
Pharmacist	6
Alternative therapist	22
Treatments officer	20
Other HIV/AIDS organisation staff	41
Positive Women's Organisation	8
Injecting drug user's organisation	3
Haemophilia Foundation	7
HIV positive friends	37
Other friends	13
Partner/lover	27
Family	21
Gay press	10
HIV magazine/newspaper	53
Internet	13

The HIV-related publications most read by heterosexual male PLWHA are *Positive Life* (52%), *Positive Living* (42%), *Talkabout* (41%), *HIV Herald* (33%), and *With Complements* (28%).

We asked respondents whether they thought lack of information made it difficult to make decisions about various issues surrounding living with HIV. Heterosexual male respondents most felt a lack of information when making decisions on managing side effects (30%), interactions between antiretrovirals and other medications (22%), having children (16%) and changing antiretroviral therapies.

Over two-fifths (42%) of heterosexual male PLWHA had experienced less favourable treatment than other people when attending a medical service. This is a somewhat higher (but not significantly so) than that reported by other PLWHA (31%).

In the last 6 months the health services that heterosexual male PLWHA had most commonly used were an HIV specialist/physician (62%), an HIV organisation clinic (44%), a hospital outpatient clinic (42%), a GP who specialises in HIV (39%), a hospital social worker/counsellor (23%), an AIDS organisation social worker (19%), a sexual health centre (17%), a hospital inpatient clinic (16%), and an employment agency (9%).

Ninety percent of heterosexual male PLWHA know other PLWHA. Respondents were asked to indicate how much of their free time they spend with other HIV seropositive people. The results in Table 7 (below) show that many heterosexual male PLWHA spend no free time with other

positive people and only two-fifths 'some' or 'a lot' of time with other positive people. Heterosexual male PLWHA were significantly more likely to report spending no time with other PLWHA than other PLWHA (17%). Fourteen percent of heterosexual male PLWHA has been involved in the care or nursing of another PLWHA within the last two years, a significantly lower proportion than that reported by other PLWHA (29%). However, they were significantly more likely not to have known someone who had died of AIDS than other PLWHA (42% v 14%).

Table 7 Amount of free time spent with other HIV positive people

Amount of free time	Heterosexual males (%)
None	40
A little	38
Some	10
A lot	11

One in ten (10%) heterosexual male PLWHA has not disclosed their HIV status to anyone. Most (67%) have had their HIV status disclosed when they didn't want it to be. Respondents were asked to rate the amount of support they received from people with different relationships to them on a scale of 1 ('a lot') to 4 ('none'). Heterosexual male PLWHA received the most support from their partners (mean=1.57) and their parents (mean=1.85). Heterosexual male PLWHA reported getting significantly less support from HIV positive friends, close friends and pets than other PLWHA.

Items were included in the questionnaire to assess respondents' experience of depressive symptoms, body image and the meaning of HIV in their lives. The results from heterosexual male respondents can be seen in Table 8 (below). We can look at the first four items in the table (adapted from the Beck Depression Inventory) as a way of measuring the extent of depressive symptoms (Judd and Mijch 1994). Among heterosexual male PLWHA 34% agreed or strongly agreed with none of these items, 28% with one item, 13% with two, 16% with three and 7% with all four. Agreement with all four items is suggestive of clinical depression. Heterosexual male respondents were ambivalent about their body image. About half (51%) of respondents agreed or strongly agreed that they were happy with the way their body looks, however 55% agreed or strongly agreed that changes in their bodies due to HIV/AIDS had made them sexually unattractive. Heterosexual respondents had a negative attitude to their HIV. Most (69%) report that they prefer not to think about HIV as long as they are well, most (64%) disagreed that their life had become more meaningful since they were diagnosed with HIV.

Table 8 Attitudes around personal well-being among the heterosexual male sample (%)

	strongly agree	agree	disagree	strongly disagree
I cry or feel like crying all the time *	6	13	54	27
I don't enjoy things the way I used to *	11	43	34	12
I have lost interest in other people *	10	26	42	22
I don't feel it's worth going on *	4	18	53	25
As long as I'm well I prefer not think about HIV/AIDS	22	47	26	5
Changes in my body due to HIV/AIDS have made me feel sexually unattractive	14	41	34	11
I am happy with the way my body looks	2	49	29	19
Life has become more meaningful since I became HIV positive	14	22	41	23

* Adapted from the BDI

Planning for the future

Respondents were asked to indicate how far into the future they plan when making major decisions about their future. Table 9 (below) shows the responses given by heterosexual male PLWHA. As in 1997, heterosexual male PLWHA were significantly more likely than other PLWHA to plan one day at a time. Almost half (44%) of heterosexual male PLWHA have changed how far they plan into the future in the last two years, of whom 75% had started planning for a longer time frame.

Table 9 Time frame use by PLWHA when planning for the future

Time frame used	Heterosexual males (%)
One day at a time	39
A few months ahead	17
1 year ahead	17
5 years ahead	14
10 or more years ahead	14

Employment

Almost two-thirds (65%) of heterosexual male PLWHA were not in paid employment at the time of completing the survey. Of the PLWHA who are working, 50% work full-time and 50% work part-time. Most heterosexual male PLWHA (87%) reported that being HIV positive has affected their career plans - 30% report that it is more difficult to plan, 26% report that having a career is no longer as important, 25% report that they stopped work, 16% have changed careers since diagnosis and 7% report they are now less likely to change their career. When asked the effect of antiretrovirals on their work plans 34% said they haven't changed, 15% that they haven't used antiretrovirals, 13% that they stopped work and 10% that they considered returning to the workforce. Nearly one in three (31%) of heterosexual male PLWHA report having been discriminated against at work as a result of having HIV/AIDS.

Sixty-one percent of heterosexual male PLWHA who have ever worked have stopped doing so at some stage due to their HIV diagnosis. These PLWHA stopped work for an average three years and two months. The last time they stopped working the most common reasons were stress or depression (56%), low energy (44%) and poor health (29%). When asked their HIV status at the time they stopped work 40% reported they were HIV positive but had not been ill, 17% they were HIV positive and had been ill, and 43% that they had been diagnosed with an AIDS defining illness. When they were not working 76% received government benefits. Over half (56%) of these PLWHA have returned to work. The most common reasons for returning to work were financial (68%), and better physical health (53%). Heterosexual men (26%) were less likely than heterosexual women (71%) to return to work because of better psychological health.

The 35% of heterosexual male PLWHA who are presently working work an average of 35.7 hours per week. Most (64%) percent report that their job involves either a moderate or high stress level, but none reported a very high stress level. Half (50%) of those in work reported no problems keeping their HIV status confidential, and a further 18% reported that they didn't try to keep their HIV status confidential. Among the rest, problems in maintaining confidentiality included visible signs of illness and gossip. Forty-one percent of heterosexual male PLWHA who are working reported that their capacity to perform their work duties is affected by having HIV/AIDS: these respondents reported that they tire quickly, work fewer hours and have difficulty concentrating. Seventy-eight percent of workers reported that they could 'often' or 'always' get time off work for medical appointments, 36% for counselling, 77% for sick leave, and 23% for volunteer work.

Fifty-one percent of heterosexual male PLWHA indicated that they are considering changing their work arrangements. Of these 39% want to start or return to work, 39% want to change the type of work they do, 19% want to increase their hours, 19% want to reduce their hours. Most of the PLWHA who want to change their work arrangements perceived that this would be difficult: 36% believe it will be 'very difficult', 42% believe that it will be 'somewhat difficult' and 23% that it will be 'not at all' difficult.

Finances

Given the large number of heterosexual male PLWHA who are not in paid employment, it is not surprising that 70% of these respondents reported that their main source of income is a government benefit, pension, or social security payment. The mean income reported by heterosexual males was \$379.96 per week. Respondents' incomes are displayed in Table 10 (below).

The poverty lines published by the Institute for Applied Economics and Social Research (IAESR) take into account an individual's income as well as whether or not they are in a relationship and the number of dependent children they have. The data for the September quarter of 1999

(IAESR, 1999) were used to calculate the percentage of PLWHA with incomes below the poverty threshold. Among heterosexual male PLWHA, 35% reported incomes below the poverty line – a similar percentage to that reported by other PLWHA.

Table 10 Income reported by PLWHA

Weekly income	Yearly income	Percentage
\$0 - \$150	\$0 - \$7800	11.6
\$151 - \$270	\$7801 - \$14040	32.6
\$271 - \$390	\$14041 - \$20280	18.6
\$391 - \$510	\$20281 - \$26520	9.3
\$511 - \$630	\$26521 - \$32760	11.6
\$631 - \$750	\$32761 - \$39000	7.0
\$751 -	\$39001 -	9.3

Respondents were asked a series of questions that assessed how difficult it is for them to meet the costs of living with HIV/AIDS. The results in Table 11 (below) demonstrate that while many heterosexual male PLWHA reported difficulties in meeting the costs of social activities such as entertainment and going out, a large proportion reported that it is very difficult for them to meet the costs of some of the 'basics' of life such as housing, utilities, food, and clothing.

Particularly noteworthy is the finding that more than one in eight heterosexual male PLWHA find it 'very difficult' to meet the cost of food, and that almost a third find it 'very difficult' to meet the cost of clothing. It is also interesting to note one-quarter of the respondents who use complementary/alternative therapies find it very difficult to meet the cost of this treatment. Heterosexual men reported significantly greater difficulty than homosexual/bisexual men in meeting the costs of co-payments for HIV/AIDS related prescribed medication and other medications.

Table 11 Difficulties meeting the cost of living reported by PLWHA (percentage of respondents who use each item)

Item	Not Difficult	A little difficult	Very difficult
Co-payment for medication for AIDS	41	45	14
Other prescribed medication	40	48	13
Medical services	46	33	21
Complementary therapies	33	45	22
Support services	72	20	8
Entertainment	17	42	41
Going out	13	40	47
Sport	31	39	29
Recreational drugs	10	46	44
Travel / holidays	10	44	4
Rent / mortgage / housing	40	40	20
Utilities (phone, gas, etc.)	25	51	24
Food	27	58	16
Clothing	22	49	29
Transport	39	45	16
Child care	22	51	27

Recreational drug use

Table 12 (below) compares the rate of use of non-prescription drugs of heterosexual male PLWHA with the general population using data from the 1998 National Drug Strategy Household Survey (AIHW, 1999). While alcohol, the most commonly used drug, was used by a comparable percentage of heterosexual male PLWHA to the general population, considerably greater percentages use most other recreational drugs. Most were happy with the amount of drugs they took. Seventy-two percent either disagreed or strongly disagreed with the statement that they use illegal drugs more than they would like, and 76% disagreed or strongly disagreed that they drink more alcohol than they would like. Only 14% reported ever missing a dose of antiretrovirals due to the use of illegal drugs.

Table 12 Use of non-prescription drugs in the past 12 months and general population rates (%)

	Heterosexual men	General population
Alcohol	76.9	80.7
Cigarettes	65.7	26.4
Marijuana	57.3	17.9
Heroin (injected)	17.2	0.7*
Methadone (prescribed)	14.8	0.2
Amyl	11.4	0.8
Speed (injected)	9.7	3.6*
Speed (not injected)	5.7	3.6*
Steroids (injected)	4.8	0.2
Cocaine (injected)	3.7	1.4*
Cocaine (not injected)	0.4	1.4*
Ecstasy	0.0	2.4
LSD/trips	0.0	3.0
Heroin (not injected)	0.0	0.7*
Methadone (non-prescribed)	0.0	0.2

*Rates in the AIHW report do not differentiate between injected and administered through other means. General population rates given for any use of substance.

Housing

Heterosexual male respondents most commonly (49%) live in an inner suburban area of a capital city, 26% live in an outer suburban area of a capital city, 18% live in a regional centre and 7% live in a rural area.

Table 13 (below) shows that heterosexual male PLWHA most commonly own their home or are buying their own home, many are living in rental accommodation, while a small number live rent-free or in community housing. The vast majority (78%) of heterosexual male respondents believe that their current housing is suitable for their needs. Unlike 1997, this percentage is no longer lower than that for other PLWHA. Forty-eight percent of heterosexual male PLWHA have changed their accommodation as a result of having HIV/AIDS.

Table 13 Accommodation in which PLWHA live (%)

Accommodation Type	Heterosexual men
Own or purchasing own house or flat	49
Private rental accommodation	26
Public rental accommodation	15
Live rent-free	8
Community housing	2

When asked whom they live with, 29% of heterosexual male PLWHA reported that they live alone, 39% live with a sexual partner, 22% live with dependent children, 19% live with friends or housemates, and 9% live with other family members.

Sexual Relationships

A large percentage (49%) of heterosexual men were not currently sexually active and a sizable percentage were in a monogamous regular relationship (38%), while few reported casual sex only (12%) or being in a non-monogamous regular relationship (2%).

Thirty-eight percent of heterosexual male respondents who have a regular relationship are in a sero-concordant relationship - the remainder (62%) are in a relationship with an HIV seronegative partner. All but two (93%) of the heterosexual male respondents who are in a regular relationship have told their partner that they are HIV seropositive. These respondents most commonly told their partner when they found out (59%), that their partner already knew they were HIV positive when they started the relationship (15%) or they were told at the beginning of the relationship (15%). Many respondents (41%) said that it did not make any difference, 60% reported that their partner was very supportive, and 44% said that they became closer, while 33% said that their partner was worried or scared and 15% said that their partner was angry.

When asked about their patterns of condom use during sex with regular partners in the 6 months prior to completing the survey, 50% reported that they always used a condom, 21% reported that they sometimes used a condom, and 29% reported that they never used a condom. Small numbers meant that it was not possible to analyse the relationship between regular partner serostatus and consistency of condom use for the heterosexual respondents.

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